NOTICES OF FINAL RULEMAKING

The Administrative Procedure Act requires the publication of the final rules of the state's agencies. Final rules are those which have appeared in the *Register* 1st as proposed rules and have been through the formal rulemaking process including approval by the Governor's Regulatory Review Council. The Secretary of State shall publish the notice along with the Preamble and the full text in the next available issue of the *Arizona Administrative Register* after the final rules have been submitted for filing and publication.

NOTICE OF FINAL RULEMAKING

TITLE 15. REVENUE

CHAPTER 5. DEPARTMENT OF REVENUE
TRANSACTION PRIVILEGE AND USE TAX

PREAMBLE

1. Sections Affected — Rulemaking Action
   R15-5-2007 — Amend

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):
   Authorizing statutes: A.R.S. §§ 42-105 and 42-1303

   Implementing statutes: A.R.S. § 42-1322.04

3. The effective date of the rules:
   August 13, 1996

4. A list of all previous notices appearing in the Register addressing the final rule:
   Notice of Rulemaking Docket Opening:
   1 A.A.R. 1783, October 6, 1996

   Notice of Proposed Rulemaking:
   1 A.A.R. 2700, December 15, 1996

   Correction to Notice of Proposed Rulemaking:
   2 A.A.R. 681, January 12, 1996

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name:	Christie Comanita, Tax Analyst Tax Research and Analysis Section
Address:	Department of Revenue 1600 West Monroe Phoenix, Arizona 85007
Telephone:	(602) 542-4672
Fax:	(602) 542-4860

6. An explanation of the rule, including the agency's reasons for initiating the rule:
   In 1994, the Arizona Legislature enacted A.R.S. § 42-1322.04 re-establishing the credit for expenses incurred by a taxpayer in accounting and reporting transaction privilege an severance taxes. The credit is effective for reporting periods beginning July 1, 1995. There had been a similar credit in effect between 1985 and 1990. The rule is adopted as amended to implement the provisions under the new statute.

7. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:
   Not applicable.

8. The summary of the economic, small business, and consumer impact:
   Identification of the Rulemaking:

   The rule implements the legislative directive that the credit for accounting and reporting expenses be made available to transaction privilege taxpayers. The purpose of the rule is to provide guidance in calculating and claiming the credit.

   The data used in preparation of the economic, small business, and consumer impact statement includes figures obtained from the annual report of transaction privilege and severance taxes remitted. The costs associated with the rule will generally be borne by the state transaction privilege tax clearing account and the general fund. However, due to the statutory definition of "taxpayer" and

the dollar limitation placed on the allowable credit, a taxpayer having more than 1 transaction privilege tax license, and taxable business activities exceeding $20 million, will bear the burden of determining whether it will allocate the allowable credit amount to 1 or more of its licenses and reporting any allocation to the Department. Benefits will accrue to the transaction privilege taxpayers claiming the credit. The benefits of the rule will be greater than the costs.

9. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):
The changes reflect the recommendations by GRRC staff from a courtesy review. The changes, all nonsubstantive, make the rule more clear and concise.

10. A summary of the principal comments and the agency response to them:
The Department did not receive any written or verbal comments on the rule after the publication of the rule in the Notice of Proposed Rulemaking.

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:
None.

12. Incorporations by reference and their location in the rules:
None.

13. Was this rule previously adopted as an emergency rule?
No.

14. The full text of the rule follows:

TITLE 15. REVENUE

CHAPTER 15. DEPARTMENT OF REVENUE
TRANSACTION PRIVILEGE AND USE TAX

ARTICLE 20. GENERAL

Section
R15-5-2007. Credit for Accounting and Reporting Expenses

ARTICLE 20. GENERAL

R15-5-2007. Credit for Accounting and Reporting Expenses

A. For purposes of this rule, the following definitions apply:
1. "Reporting period" means a calendar month unless another period is authorized pursuant to A.R.S. § 42-1322.
2. "Statutory delinquency date" means the date by which a payment of tax is considered delinquent pursuant to A.R.S. § 42-1322.
3. "Tax return" means the Transaction Privilege, Use, and Severance Tax Return (TPT-1).
4. "Taxable business" means a business which is subject to either transaction privilege or severance tax.
5. "Taxpayer" means taxpayer as defined in A.R.S. § 42-1322.04(C), including an entity which is exempt from state income tax. The following are considered a single taxpayer:
   a. Members of an Arizona affiliated group filing a consolidated corporate income tax return under A.R.S. § 43-947;
   b. Corporations in a unitary business filing a combined corporate income tax return under A.A.C. R15-2-1131(E);
   c. Married taxpayers operating separate sole proprietorships and filing a joint income tax return under A.A.C. R15-2-1131(E); or
   d. Partnerships, S Corporations, trusts, or estates conducting multiple businesses, filing a single income tax return.

B. A taxpayer shall compute the credit, using the full amount of tax as required to be reported on the tax return, including any excess tax collected. The Department shall not allow a credit against taxes other than the state transaction privilege tax and the severance tax. ~~Amount of credit. The credit given for accounting and reporting expenses applies to the full amount of the transaction privilege tax and severance tax due as computed on the sales tax return and actually remitted on or before the statutory delinquency date.~~

C. Except as provided in subsection (D), the Department shall not allow a credit if the taxpayer fails to pay the tax due before the statutory delinquency date. Failure to pay the tax due includes the following circumstances:
1. ~~If~~ The ~~the~~ taxpayer ~~only~~ makes an underpayment ~~a partial payment~~ of tax due, including any estimated tax due, or, ~~the tax due will not have been paid and no credit shall be allowed.~~
2. ~~If~~ The ~~the~~ taxpayer's check is dishonored., ~~it shall be treated the same as a nonpayment, and no credit shall be allowed. If the taxpayer includes excess tax collected in its sales tax return, the excess tax collected is subject to the credit.~~

D. ~~Effect of taxpayer error on receiving the credit.~~ In the case of taxpayer computational error, the Department shall allow the credit ~~shall be given when the taxpayer attempted to compute and pay the tax on time, and there was an error in mathematical~~ based on the amounts originally filed, if the computational ~~computation~~ error ~~that~~ resulted in the overpayment or underpayment of the tax actually due.:
1. In the case of an overpayment, the Department shall allow ~~Overpayment, If the mathematical error results in overpayment of the tax due, the credit shall be given on~~ the actual amount of tax due for the reporting period. ~~Any overpayment of tax due may be refunded or used as a credit balance to offset future tax liabilities. Overpayment used to offset future tax liabilities shall be considered to be part of the amount paid in the following reporting period and subject to the credit at that time.~~
2. In the case of an underpayment, the Department shall allow ~~Underpayment, If the taxpayer makes a mathematical error in computing the amount of tax due which results in an underpayment, if the taxpayer shall be given~~ the credit ~~only~~ on the amount of the tax paid prior to the statutory delinquency date.

E. ~~Claiming the credit.~~ To receive the credit for each reporting period, the taxpayer shall claim the credit on the ~~sales~~ tax return. If ~~the credit is miscalculated~~ the taxpayer understates the amount of the credit on the tax return, the Department shall allow ~~taxpayer shall be given~~ the amount of credit ~~actually due for the reporting period rather than the miscalculated amount~~ which the taxpayer has claimed. The taxpayer may file an amended return to claim any unclaimed portion of the credit if the taxpayer timely paid the tax upon which the credit is based. If the taxpayer overstates the amount of the credit, the Department shall allow the amount of credit actually permitted for the reporting period.

F. A taxpayer is entitled to 1 credit, regardless of the number of licenses, businesses, or locations the taxpayer may have. Taxpayers with multiple licenses for separate businesses or separate locations shall elect the manner in which to allocate the credit among their licenses within the $10,000 annual limitation. The election shall be made on a form 51-T. The taxpayer shall file the election on or before January 15 of the 1st year for which an election if being made or within 30 days prior to beginning operations if the taxpayer is a new business entity. The taxpayer is required to file an election 1 time; however, a new election may be filed under the following circumstances:

1. If a taxpayer does not claim the entire $10,000 credit during the calendar year, the taxpayer may amend the election at the end of the calendar year to reallocate the unclaimed portion of the credit for that particular year. This amended election shall be filed on or before January 31 of the following year. To claim the reallocated credit, the taxpayer shall file an amended tax return for each reporting period in which a sufficient tax was due and timely paid. For example: an individual owns 3 separate businesses with different transaction privilege tax licenses. At the beginning of the year, the individual allocates the $10,000 credit as follows: $3,000 to Company A; $2,000 to Company B; and $5,000 to Company C. At the end of the year, Companies A and B have claimed the credit up to their allocated amounts. However, Company C has only claimed $1,000 of its allocated credit. Company A timely paid a sufficient amount of tax during the months of August and September to qualify for an additional $4,000 credit. The individual may amend the election to reallocate the unclaimed credit to Company A. To claim the $4,000 credit, the individual must file an amended tax return for Company A for the months of August and September.
2. If a taxpayer acquires, sells, or terminates a taxable business during the calendar year, the taxpayer may amend the election at that time to reallocate the credit. The taxpayer shall only reallocate the portion of the credit which has not been claimed by the date on which the taxpayer acquires, sells, or terminates the business. The taxpayer shall ensure that the election relates to the acquired, sold, or terminated business and is made on a prospective basis only. The taxpayer shall notify the Department of the reallocation 30 days prior to the due date of the tax return for the reporting period to which the reallocation applies. For example: Corporation A is the common parent of Corporations B and C and elects to file a consolidated corporate state income tax return. Each of the 3 corporations conducts a taxable business activity. Since the 3 corporations file state income tax as 1 entity, Corporation A is required to allocate the $10,000 credit among the 3 corporations. At the beginning of the year, Corporation A elects to allocate the entire $10,000 credit to Corporation B. On July 1, Corporation A acquires Corporation D which also conducts a taxable business activity. Corporation A may amend its election at this time to take into account Corporation D. Corporation A may reallocate the portion of the credit not already claimed by Corporation B to Corporation D.

G. Where a taxpayer is allocating the $10,000 credit, the following rules apply:

1. The Department shall allow a unitary business, filing a combined corporate state income tax return, or an Arizona affiliated group, filing a consolidated corporate state income tax return, 1 $10,000 credit. The unitary business or affiliated group may allocate the credit among its members. If the unitary business or affiliated group fails to allocate the $10,000 credit, the Department shall allocate the credit to the corporation in whose name the unitary business or affiliated group files its state income tax return regardless of whether the corporation conducts a taxable business.
   a. If a corporation joins an Arizona affiliated group or unitary business during the calendar year, the Department shall classify the corporation as a separate taxpayer for the period before it joins the affiliated group or unitary business. The Department shall classify the corporation as the same taxpayer, an affiliated group, or unitary business for the period after it joins the affiliated group or unitary business. An affiliated group or unitary business may allocate the $10,000 credit, even if a member corporation claimed the credit before it joined the affiliated group or unitary business.
   b. If a corporation leaves an affiliated group or unitary business during the calendar year, the Department shall classify the corporation as the same taxpayer, an affiliated group, or unitary business for the period before it leaves the affiliated group or military business. The Department shall not classify the corporation as the same taxpayer for the period after it leaves the affiliated group or unitary business. The corporation, as a separate taxpayer or part of a separate taxpayer, may allocate the $10,000 credit, even if the corporation claimed the credit before it left an affiliated group or unitary business.
2. If a partnership, S corporation, trust, or estate conducts multiple taxable businesses, the Department shall allow the partnership, S corporation, trust, or estate 1 $10,000 credit. The partnership, S corporation, trust, or estate may allocate the credit among its businesses. The credit shall not be allocated to the partners of a partnership, shareholders of an S corporation, or beneficiaries of a trust or estate.
3. In cases where the taxpayers are married and each spouse conducts a taxable business, the Department shall allow 1 $10,000 credit per income tax return. If the married taxpayers file separate individual income tax returns, the Department shall allow each spouse 1 $10,000 credit. If the married taxpayers file a joint income tax return, the Department shall allow 1 $10,000 credit for the couple.

NOTICE OF FINAL RULEMAKING

TITLE 20. PROFESSIONS AND OCCUPATIONS

CHAPTER 6. DEPARTMENT OF INSURANCE

PREAMBLE

1. Sections Affected / Rulemaking Action

Sections Affected	Rulemaking Action
R20-6-1101	Amend
R20-6-1102	Amend
R20-6-1104	Amend
R20-6-1105	Amend
R20-6-1108	Amend
R20-6-1110	Amend
R20-6-1113	Amend
R20-6-1114	Amend
Appendix B	Amend
Appendix C	Amend
Appendix D	Amend
Appendix F	New Appendix

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

   Authorizing statutes: A.R.S. §§ 20-143, 20-1133; 42 U.S.C. § 1395ss

   Implementing statutes: A.R.S. § 20-1133; 42 U.S.C. § 1395ss

3. The effective date of the rules:

   August 16, 1996

4. A list of all previous notices appearing in the Register addressing the final rule:

   Notice of Rulemaking Docket Opening:
   2 A.A.R. 1197, March 8, 1996

   Notice of Proposed Rulemaking:
   2 A.A.R. 1256, March 22, 1996

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

   Name: Gregory Y. Harris

   Address: Department of Insurance
   2910 North 44th Street, Suite 210
   Phoenix, Arizona 85018

   Telephone: (602) 912-8451

   Tax: (602) 912-8452

6. An explanation of the rule, including the agency's reasons for initiating the rule:

   Medicare Supplement insurance is regulated by the state based on minimum standards prescribed by federal law. These changes reflect changes to federal law prescribed pursuant to 42 U.S.C. § 1395ss (a) and (b). In addition, disclosure forms dictated by federal law will be adopted. Without these changes, Medicare Supplement insurance policies may not be sold in Arizona, except as directly regulated by the federal Department of Health and Human Services/Health Care Financing Administrations (DHHS/HCFA). Now, 42 U.S.C. § 1395ss (a) and (b) requires DHHS/HCFA to certify that a state's Medicare supplement regulatory program meets the current standards of the Model Medicare Supplement Act and Regulation adopted by the National Association of Insurance Commissioners. These changes precisely mirror the changes required by DHHS/HCFA.

7. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

   Not applicable.

8. The summary of the economic, small business, and consumer impact:

   These amendments are required by federal law of all issuers of Medicare Supplement insurance. Any cost associated with these amendments is the result of federal law and not the result of adoption of these amendments.

9. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

   The Department corrected a citation to 42 U.S.C. § 1395ss(g)(1) in R20-6-1102(16).

   The Department amended the text of Appendix B to insert the word "generally" as required by the format prescribed by DHHS/HCFA regarding the level of benefits.

The Department amended the text of Appendix B to insert a missing dollar sign.

The Department corrected a misspelling of the word "receive" in Appendix B, Plan E.

The Department corrected a misspelling of the word "specified" in Appendix F.

The Department deleted a duplicate "the" from Appendix F.

Further, in response to comments from GRRC staff, the Department made a number of nonsubstantive changes to clarify the text of the rules.

10. **A summary of the principal comments and the agency response to them:**
The agency received no written or oral comments concerning the rule.

11. **Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:**
Not applicable.

12. **Incorporations by reference and their location in the rules:**
Not applicable.

13. **Was this rule previously adopted as an emergency rule?**
No.

14. **The full text of the rule follows:**

TITLE 20. PROFESSIONS AND OCCUPATIONS

CHAPTER 6. DEPARTMENT OF INSURANCE

ARTICLE 11. MEDICARE SUPPLEMENT INSURANCE

Section
R20-6-1101. Applicability and Scope
R20-6-1102. Definitions
R20-6-1104. Minimum Benefit Standards for Policies or Certificates Issued for Delivery Before ~~Prior to~~ April 1, 1992
R20-6-1105. Benefit Standards for Policies or Certificates Issued or Delivered on or After April 1, 1992
R20-6-1108. Open Enrollment
R20-6-1110. Loss Ratio Standards and Refund or Credit of Premium
R20-6-1113. Required Disclosure Provisions
R20-6-1114. Requirements for Application Forms and Replacement Coverage
APP. B. MEDICARE SUPPLEMENT COVERAGE PLANS
APP. C. STATEMENTS AND QUESTIONS
APP. D. NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE
APP. F. MEDICARE DUPLICATION DISCLOSURE STATEMENTS

ARTICLE 11. MEDICARE SUPPLEMENT INSURANCE

R20-6-1101. Applicability and Scope

A. Except as otherwise specifically provided in R20-6-1104, R20-6-1109, R20-6-1110, R20-6-1113 and R20-6-1118, this Article applies ~~shall apply~~ to:
1. All Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this Article ~~hereof~~; and
2. All certificates issued under group Medicare supplement policies and~~, which certificates have been~~ delivered or issued for delivery in this state.

B. This Article does ~~shall~~ not apply to a policy or contract of 1 ~~one~~ or more employers or labor organizations, or of the trustees of a fund established by 1 ~~one~~ or more employers or labor organizations or combination of employers and labor organizations ~~thereof~~, for employees, ~~or~~ former employees, or a combination of employees and former employees ~~thereof~~, or for members, ~~or~~ former members, or a combination of members and former members ~~thereof~~, of the labor organizations.

R20-6-1102. Definitions

1. "Activities of daily living" means ~~include~~, but is ~~are~~ not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.
2. "Applicant" means:
   a. In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; and
   b. In the case of a group Medicare supplement policy, the proposed certificate holder.
3. "At-home recovery visit" means the period of time ~~a visit~~ required to provide at-home recovery care, without limit on the duration of time ~~the visit~~, except each consecutive 4 ~~four~~ hours in a 24-hour period of services provided by a care provider is 1 ~~one~~ visit.
4. "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.
5. "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.
6. "Certificate form" means the form on which a ~~the~~ certificate is delivered or issued for delivery by an ~~the~~ issuer.
7. "Compensation" means ~~any~~ pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of a ~~the~~ policy or certificate including but not limited to bonuses, gifts, prizes, awards, and finders' fees.
8. "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.
9. "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services of ~~concerning~~ a Medicare Select

issuer or its network providers.

10. "Home" means ~~shall mean~~ any place used by an ~~the~~ insured as a place of residence, provided that the ~~such~~ place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.
11. "Issuer" means ~~includes~~ insurance companies, fraternal benefit societies, health care services organizations, hospital and medical service associations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.
12. "Medicare" means the "Health Insurance for the Aged Act", Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.
13. ~~The~~ "Medicare Handbook" means ~~shall refer to~~ the publication distributed by the United States Department of Health and Human Services, Health Care Financing Administration, describing Medicare benefits available and premium, deductible, and coinsurance amounts payable.
14. "Medicare Select issuer" means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.
15. "Medicare Select policy" or "Medicare Select certificate" mean respectively a Medicare supplement policy or certificate that contains restricted network provisions.
16. "Medicare supplement policy" means a group or individual policy of disability insurance or a subscriber or member contract of hospital and medical service associations or health care services organizations, other than a policy issued pursuant to a contract under Section 1876 ~~or Section 1833~~ of the federal Social Security Act (42 U.S.C. §§ 1395 et seq.) or a policy issued ~~an issued policy~~ under a demonstration project ~~authorized pursuant to amendments to the federal Social Security Act~~ specified in 42 U.S.C. § 1395ss Subsection (g)(1), which is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare.
17. "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with an ~~the~~ issuer to provide benefits insured under a Medicare Select policy.
18. "Policy form" means a ~~the~~ form on which a ~~the~~ policy is delivered or issued for delivery by an ~~the~~ issuer.
19. "Restricted network provisions" means any provision that ~~which~~ conditions the payment of benefits, in whole or in part, on the use of network providers.
20. "Service area" means the geographic area within which an issuer is authorized to offer a Medicare Select policy.

R20-6-1104. Minimum Benefit Standards for Policies or Certificates Issued for Delivery Before ~~Prior to~~ April 1, 1992

A. No policy or certificate may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits that ~~which~~ are not inconsistent with these standards.

B. The following standards apply to Medicare supplement policies and certificates ~~certificate~~ and are in addition to all other requirements of this Article.

1. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than 6 ~~six~~ months after the effective date of coverage because the losses arise from ~~it involved~~ a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 ~~six~~ months before the effective date of coverage.
2. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.
3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with these ~~such~~ changes.
4. A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" Medicare supplement policy shall not:
   a. Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or
   b. Be cancelled or nonrenewed by the issuer solely on the grounds of deterioration of health.
5. An issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation without prior written authorization from the director. The director may authorize cancellation or nonrenewal for reasons other than nonpayment of premium or material misrepresentation if the director finds that the renewal or continuation of the Medicare supplement policy or certificate would be hazardous or prejudicial to the issuer's certificate holders or policyholders.
6. If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in subsection (B)(8), ~~paragraph (8) of this subsection,~~ the issuer shall offer certificate holders an individual Medicare supplement policy. The issuer shall offer the certificate holder at least the following choices:
   a. An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and
   b. An individual Medicare supplement policy that ~~which~~ provides only the ~~such~~ benefits ~~as are~~ required to meet the minimum standards ~~as~~ described in R20-6-1105(C).
7. If membership in a group is terminated, the issuer shall:
   a. Offer the certificate holder the ~~such~~ conversion opportunities ~~as are~~ described in subsection (B)(6) ~~paragraph (6) of this subsection;~~ or
   b. At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.
8. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the ~~succeeding~~ issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the replacement ~~new~~ group policy shall not exclude ~~result in any exclusion for~~ preexisting conditions that would have been covered under the group policy being replaced.
9. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss that ~~which~~ commenced while the policy was in force, but the

extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits.

C. Minimum benefit standards.
1. Coverage of Part A Medicare-eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;
2. Coverage for either all or none of the Medicare Part A inpatient ~~impatient~~ hospital deductible amount;
3. Coverage of Part A Medicare-eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient ~~impatient~~ reserve days;
4. Upon exhaustion of all Medicare hospital inpatient ~~impatient~~ coverage including the lifetime reserve days, coverage of 90% ~~percent~~ of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;
5. Coverage under Medicare Part A for the reasonable cost of the first 3 ~~three~~ pints of blood or equivalent quantities of packed red blood cells unless replaced or already paid for under Part B;
6. Coverage for the coinsurance amount of Medicare- eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible [$100]; and
7. Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first 3 ~~three~~ pints of blood or equivalent quantities of packed red blood cells, unless replaced or already paid for under Part A, subject to the Medicare deductible amount.

R20-6-1105. Benefit Standards for Policies or Certificates Issued or Delivered on or After April 1, 1992

A. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after April 1, 1992. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

B. General standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this Article.
1. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than 6 ~~six~~ months from the effective date of coverage because the losses arise from ~~it involved~~ a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 ~~six~~ months before the effective date of coverage.
2. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.
3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with these ~~such~~ changes.
4. No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.
5. Each Medicare supplement policy shall be guaranteed renewable and the issuer:
   a. Shall ~~The issuer shall~~ not cancel or nonrenew the policy solely on the ground of health status of the individual; and
   b. Shall ~~The issuer shall~~ not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

6.c. If a ~~the~~ Medicare supplement policy is terminated by a ~~the~~ group policyholder and is not replaced as provided under subsection (B)(8)~~subparagraph (c) of this paragraph~~, the issuer shall offer certificate holders an individual Medicare supplement policy which, at the option of the certificate holder,
   a.i. Provides for continuation of the benefits contained in the group policy, or
   b.ii. Provides for ~~such~~ benefits that ~~as~~ otherwise meet the requirements of ~~this~~ subsection (B).

7.d. If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall
   a.i. Offer the certificate holder the conversion opportunity described in subsection (B)(6) ~~subparagraph (c) of this paragraph~~; or
   b.ii. At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

8.e. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the ~~succeeding~~ issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the replacement group ~~new~~ policy shall not exclude ~~result in any exclusion for~~ preexisting conditions that would have been covered under the group policy being replaced.

9.6. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss that ~~which~~ commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

10.7. A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period, not to exceed 24 months, in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the ~~such~~ policy or certificate within 90 days after the date the individual becomes entitled to the medical ~~such~~ assistance. ~~Upon receipt of timely notice, the issuer shall return to the policyholder or certificate holder that portion of the premium attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.~~
   a. If benefits and premiums are suspended under subsection (B)(10), ~~such suspension occurs~~ and if the policyholder or certificate holder loses entitlement to medical assistance under Title XIX of the Social

Security Act, the ~~such medical assistance, such~~ policy or certificate shall be automatically reinstituted, effective as of the date of termination of the ~~such~~ entitlement, ~~as of the termination of such entitlement~~ if the policyholder or certificate holder provides notice of loss of the ~~such~~ entitlement within 90 days after the date of the ~~such~~ loss of the entitlement and pays the premium attributable to the period beginning when the entitlement to the medical assistance ended.~~, effective as of the date of termination of such entitlement.~~

b. Reinstitution of coverage under subsection (B)(10)(a): ~~such coverages:~~
   i. Shall not provide for any waiting period with respect to treatment of preexisting conditions;
   ii. Shall provide for coverage that ~~which~~ is substantially equivalent to coverage in effect before the date of the ~~such~~ suspension; and
   iii. Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

C. Standards for basic "core" benefits common to all benefit plans.
   1. Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any ~~of the~~ other Medicare supplement insurance benefit plans in addition to the basic "core" package, but not instead of the basic "core" package. ~~in lieu thereof.~~
      a. Coverage of Part A Medicare-eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;
      b. Coverage of Part A Medicare-eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;
      c. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A-eligible expenses for hospitalization paid at the Diagnostic Related Group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days;
      d. Coverage under Medicare Parts A and B for the reasonable cost of the first 3 ~~three~~ pints of blood or equivalent quantities of packed red blood cells, unless replaced; and
      e. Coverage for the coinsurance amount of Medicare-eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

D. Standards for additional benefits.
   1. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by R20-6-1106.
      a. Medicare Part A deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period;
      b. Skilled nursing facility care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A;
      c. Medicare Part B deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement;
      d. Eighty percent of the Medicare Part B excess charges: Coverage for 80% ~~percent~~ of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge;
      e. One hundred percent of the Medicare Part B excess charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge;
      f. Basic outpatient prescription drug benefit: Coverage for 50% ~~percent~~ of outpatient prescription drug charges, after a $250 calendar-year deductible, to a maximum of $1,250 in benefits received by the insured per calendar year, to the extent not covered by Medicare;
      g. Extended outpatient prescription drug benefit: Coverage for 50% ~~percent~~ of outpatient prescription drug charges, after a $250 calendar-year deductible to a maximum of $3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare;
      h. Medically necessary emergency care in a foreign country: Coverage to the extent not covered by Medicare for 80% ~~percent~~ of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, that ~~which care~~ would have been covered by Medicare if provided in the United States and that ~~which care~~ began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" means ~~shall mean~~ care needed immediately because of an injury or an illness of sudden and unexpected onset;
      i. Preventive medical care benefit: Coverage for the following preventive health services:
         i. An annual clinical preventive medical history and physical examination that may include tests and services described in subdivision (ii) of this subparagraph and patient education to address preventive health care measures;
         ii. Any 1 or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:
            (1) Fecal occult blood test and/or digital rectal examination;
            (2) Mammogram;
            (3) Dipstick urinalysis for hematuria, bacteriuria and proteinauria;
            (4) Pure tone, air only, hearing screening test, administered or ordered by a physician;
            (5) Serum cholesterol screening every 5 ~~five~~ years;
            (6) Thyroid function test; and
            (7) Diabetes screening;

iii. Influenza vaccine administered at any appropriate time during the year and tetanus and diphtheria booster every 10 ~~ten~~ years;~~.~~

iv. Any other tests or preventive measures determined appropriate by the attending physician; and~~.~~

v. Reimbursement shall be for the actual charges up to 100% ~~percent~~ of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of $120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare;~~.~~

j. At-home recovery benefit: Coverage for services to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery,

i. Coverage requirements and limitations

(1) At-home recovery services provided must be primarily services that ~~which~~ assist in activities of daily living;~~.~~

(2) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare;~~.~~

(3) Coverage is limited to:

(a) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment;~~.~~

(b) The actual charges for each visit ~~up~~ to a maximum reimbursement of $40 per visit;~~.~~

(c) $1,600 per calendar year;~~.~~

(d) Seven visits in any 1 ~~one~~ week;~~.~~

(e) Care furnished on a visiting basis in the insured's home;~~.~~

(f) Services provided by a care provider as defined in R20-6-1102 (4); ~~R20-6-1102 (A)(4).~~

(g) At-home recovery visits while the insured is covered under the policy or ~~of~~ certificate and not otherwise excluded; and~~.~~

(h) At-home recovery visits received during the period the insured is receiving Medicare-approved home care services or no more than 8 ~~eight~~ weeks after the service date of the last Medicare-approved home health care visit.

(4) Coverage is excluded for:

a) Home care visits paid for by Medicare or other government programs; and

(b) Care provided by family members, unpaid volunteers, or providers who are not care providers; and~~.~~

k. New or innovative benefits: An issuer may, with the prior approval of the Director, offer policies or certificates with new or innovative benefits that ~~which~~ do not violate any ~~applicable~~ provision of Title 20, A.R.S., or otherwise conflict with this Article and are in addition to the benefits provided in a policy or certificate that otherwise comply with the applicable standards. The ~~Such~~ new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and ~~are~~ offered in a manner that ~~which~~ is consistent with the goal of simplification of Medicare supplement policies.

R20-6-1108. Open Enrollment

A. An ~~No~~ issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state nor discriminate in the pricing of ~~such~~ a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant who submits an application for ~~where an application for such~~ a policy or certificate before or ~~is submitted~~ during the 6 month ~~six-month~~ period beginning with the 1st day of the 1st month in which an individual ~~who~~ is 65 years of age or older ~~first~~ and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants who qualify under this subsection without regard to age.

B. Except as provided in R20-6-1119, subsection ~~Subsection~~ (A) shall not be construed as preventing the exclusion of benefits under a policy or certificate, during the first 6 ~~six~~ months of coverage, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the 6 ~~six~~ months before ~~it~~ the coverage became effective.

R20-6-1110. Loss Ratio Standards and Refund or Credit of Premium

A. Loss ratio standards.

1. A Medicare supplement policy or certificate form shall not be delivered or issued for delivery unless the policy ~~form~~ or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits, not including anticipated refunds or credits, provided under the policy ~~form~~ or certificate ~~form~~:

a. At least 75% ~~percent~~ of the aggregate amount of premiums earned in the case of group policies, or

b. At least 65% ~~percent~~ of the aggregate amount of premiums earned in the case of individual policies, calculated on the basis of incurred claims experience or incurred health care expenses if ~~where~~ coverage is provided by a health care services organization on a service rather than reimbursement basis, and earned premiums for the ~~such~~ period and in accordance with accepted actuarial principles and practices.

2. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this rule when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

3. For policies issued before December 18, 1991, expected

claims in relation to premiums shall meet:

a. The originally filed anticipated loss ratio when combined with the actual experience since inception;

b. The appropriate loss ratio requirement from subsection (A)(1) when combined with the actual experience beginning with April 28, 1996 to date; and

c. The appropriate loss ratio requirement from subsection (A)(1) over the entire future period for which the rates are computed to provide coverage.

B. Refund or credit calculation.

1. An issuer shall collect and file with the Director by May 31 of each year the data contained in the applicable reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan.
2. If on the basis of the experience as reported, the benchmark ratio since inception exceeds the adjusted experience ratio since inception, ~~then~~ a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies or certificates issued within the reporting year shall be excluded.
3. For policies or certificates issued before December 18, 1991, the issuer shall make the refund or credit calculation separately for all individual policies combined and all group policies combined for experience after April 28, 1996. The issuer shall submit the first report under this subsection by May 31, 1998.

~~3.~~4. A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds .5% of the annualized premium in force as of December 31 of the reporting year. The ~~Such~~ refund or credit shall include interest from the end of the calendar year to the date of the refund or credit at a rate not less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

C. Annual filing of premium rates.

1. An issuer of Medicare supplement policies or certificates issued in this state before or after the effective date of this rule shall file annually its rates, rating schedule, and supporting documentation, including ratios of incurred losses to earned premiums, by policy duration for approval by the Director. The supporting documentation shall also demonstrate, in accordance with actuarial standards of practice using reasonable assumptions, that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The ~~Such~~ demonstration shall exclude active life reserves. An expected third-year loss ratio that ~~which~~ is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than 3 ~~three~~ years.
2. Before ~~Prior to~~ the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the Director:
   a. Premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. Supporting ~~Such supporting~~ documents ~~as~~ necessary to justify the adjustment shall accompany the filing.
      i. An issuer shall make premium adjustments to produce an expected loss ratio under a ~~such~~ policy or certificate that conforms ~~as will conform~~ with minimum loss ratio standards for Medicare supplement policies or certificates and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the ~~such~~ Medicare supplement policies or certificates. No premium adjustment that ~~which~~ would modify the loss ratio experience under the policy or certificate other than the adjustments described in this subsection ~~herein~~ shall be made with respect to a policy or certificate at any time other than upon its renewal date or anniversary date.
      ii. If an issuer fails to make premium adjustments in accordance with this rule, the Director may order premium adjustments, refunds, or ~~premium~~ credits deemed necessary to achieve the loss ratio required by this rule.
   b. Any riders, endorsements, or policy forms needed to modify the Medicare supplement policy or certificate to eliminate benefit duplications with Medicare. The ~~Such~~ riders, endorsements, or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

D. Public hearings. The Director may conduct a public hearing or hearings to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of this rule if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the ~~such~~ reporting period. The Director shall give notice of the hearing in accordance with A.R.S. § 20-163.

E. As used in this rule, "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

R20-6-1113. Required Disclosure Provisions

A. General rules.

1. Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the renewal or continuation ~~such~~ provision shall be consistent with the type of contract issued. The ~~Such~~ provision shall be captioned as a renewal or continuation provision, ~~and~~ shall appear on the first page of the policy or certificate, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's or certificate holder's age.
2. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after the date of issue or at reinstatement or renewal that ~~which~~ reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement that ~~which~~ increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits or coverage are required by the minimum standards for Medicare supplement policies, or ~~if~~ the increased benefits or coverage is required by law. If

~~Where~~ a separate additional premium is charged for benefits or coverage provided in connection with riders or endorsements, the additional ~~such~~ premium charge shall be set forth in the policy.

3. Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import.
4. If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, the ~~such~~ limitations shall appear as a separate paragraph of the policy and be labeled as "Pre-existing Condition Limitations."
5. Medicare supplement policies and certificates shall have a notice prominently printed on or attached to the first page of the policy or certificate ~~or attached thereto~~ stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.
6. Issuers of accident and sickness policies or certificates that ~~which~~ provide hospital or medical expense coverage on an expense-incurred or indemnity basis, ~~other than incidentally,~~ to a person ~~person(s)~~ eligible for Medicare ~~by reason of age~~ shall provide to ~~such~~ the applicants a ~~Medicare Supplement Buyer's~~ Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration and in a type size no smaller than 12-point type. Delivery of the ~~Buyer's~~ Guide shall be made whether or not the ~~such~~ policies or certificates are advertised, solicited, or issued as Medicare supplement policies or certificates as defined in this Article. Except in the case of direct response issuers, delivery of the ~~Buyer's~~ Guide shall be made to the applicant at the time of application and acknowledgment of receipt of the ~~Buyer's~~ Guide shall be obtained by the issuer. Direct response issuers shall deliver the ~~Buyer's~~ Guide to the applicant upon request or, if not requested, no ~~but not~~ later than at the time the policy is delivered.
7. For the purposes of subsection (A)(6), "form" means language, format, type size, type proportional spacing, bold character, and line spacing.

B. Notice requirements.

1. As soon as practicable, but no later than 30 days before ~~prior to~~ the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies or certificates. The ~~Such~~ notice shall:
   a. Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate, and
   b. Inform each policyholder and certificate holder ~~as to~~ when any premium adjustment is to be made due to changes in Medicare.
2. The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms ~~so as~~ to facilitate comprehension.
3. The ~~Such~~ notices shall not contain or be accompanied by any solicitation.

C. Outline of coverage requirements for Medicare supplement policies.

1. Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgment of receipt of the ~~such~~ outline from the applicant.~~; and~~
2. If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis that ~~which~~ would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the ~~such~~ policy or certificate when it is delivered and contain the following statement, in no less than 12- point type, immediately above the company name:

   "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."
3. The outline of coverage provided to applicants pursuant to this rule consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed in Appendix B ~~below~~ in no less than 12-point type. The standard ~~All~~ plans A-J shall be shown on the cover page, and the plans ~~plan(s)~~ that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and payment frequency ~~mode~~ shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.
4. The outline of coverage shall include the items in the order prescribed in Appendix B.

D. Notice regarding policies or certificates that ~~which~~ are not Medicare supplement policies.

1. Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy; ~~or~~ a policy issued pursuant to a contract under Section 1876 ~~or Section 1833~~ of the federal Social Security Act (42 U.S.C. 1395 et seq.), disability income policy; ~~basic, catastrophic, or major medical expense policy; single premium nonrenewable policy~~ or other policy identified in R20-6-1101(B), ~~of this Article,~~ issued for delivery in this state to persons eligible for Medicare ~~by reason of age~~ shall notify insureds under the policy or certificate that the policy or certificate is not a Medicare supplement policy or certificate. ~~Such~~ The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy or, if no outline of coverage is delivered, to the first page of the policy or certificate delivered to insureds. ~~Such~~ The notice shall be in not less than 12-point type and shall contain the following language:

   "THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the ~~Medicare Supplement Buyer's~~ Guide to Health Insurance for People with Medicare available from the company.
2. Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in subsection (D)(1) shall disclose, using the applicable statement in Appendix F, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

R20-6-1114. Requirements for Application Forms and Replacement Coverage

A. Application forms shall include the questions set forth in Appendix C, designed to elicit information as to whether, as of the date of the application, the applicant has another Medicare supplement or other health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing the ~~such~~ questions and statements set forth in Appendix C may be used.

B. Agents shall list in the application any other health insurance policies they have sold to the applicant.

1. List policies sold that ~~which~~ are still in force.
2. List policies sold in the past 5 ~~five~~ years that ~~which~~ are no longer in force.

C. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the issuer, shall be returned to the applicant by the issuer upon delivery of the policy.

D. Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, before ~~prior to~~ issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of the ~~such~~ notice signed by the applicant and the agent, unless ~~except where~~ the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy or certificate the notice regarding replacement of Medicare supplement coverage.

E. The notice required by subsection (D) ~~of this rule for an issuer~~ shall be provided in substantially the form prescribed ~~form~~ in Appendix D in no less than ~~10~~ 12-point type.

APPENDIX B
[12 point]
[COMPANY NAME]
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE - COVER PAGE:
BENEFIT PLAN(s) _____ [insert letter(s) of plan(s) being offered]

Medicare supplement insurance can be sold in only ten standard plans. This chart shows the benefits included in each plan. Every company must make available Plan "A". Some plans may not be available in your state.

BASIC BENEFITS: Included in All Plans.
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (20% of Medicare-approved expenses).
Blood: First three pints of blood each year.

A	B	C	D	E	F	G	H	I J
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
Skilled Nursing		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance
Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
Part B Deductible		Part B Deductible			Part B Deductible			
Part B Excess (100%)					Part B Excess(100%)	Part B Excess(80%)		Part B Excess(100%)
Foreign Travel Emergency		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
At-Home Recovery			At-Home Recovery			At-Home Recovery		At-Home Recovery
ExtendedDrugs ($3000 Limit)							Basic Drugs ($1250 Limit)	Basic Drugs ($1250 Limit)
Preventive Care				Preventive Care				

APPENDIX B (CONT'D)
PREMIUM INFORMATION [boldface type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this state. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES [boldface type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [boldface type]

This is only an outline, describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [boldface type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [boldface type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [boldface type]

This policy may not fully cover all of your medical costs.
[for agents]
Neither [insert company's name] nor its agents are connected with Medicare.
[for direct response:]
[insert company's name] is not connected with Medicare.
This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult 'The Medicare Handbook' for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [boldface type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]
Review the application carefully before you sign it. Be certain that all information has been properly recorded.
[Include for each plan prominently identified in the cover page a chart showing the services. Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this Article. An issuer may use additional benefit plan designations on these charts pursuant to R20-6-1106.]
[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the director.]

APPENDIX B (CONT'D)
PLAN A
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$0	$628 (Part A Deductible)
61st thru 90th day	All but $157 a day		$157 a day $0
91st day and after:			
- While using 60 lifetime reserve days	All but $314 a day		$314 a day $0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	$0	Up to $78.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

APPENDIX B (CONT'D)
PLAN A
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare-Approved Amounts * (the Part B Deductible)	$0 $0	$100	
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0 $0	All costs	
BLOOD			
First 3 pints	$0 All costs	$0	
Next $100 of Medicare-Approved Amounts *	$0 $0	$100 (Part B Deductible)	
Remainder of Medicare-Approved Amounts	80% 20%	$0	
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $100 of Medicare-Approved Amounts*	0* $0	$100 (Part B Deductible)	
Remainder of Medicare-Approved Amounts	80% 20%	$0	

APPENDIX B (CONT'D)
PLAN B
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	$0	Up to $78.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

APPENDIX B (CONT'D)
PLAN B
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare-Approved Amounts * (the Part B Deductible)	$0 $0	$100	
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0 $0	All costs	
BLOOD			
First 3 pints	$0 All costs	$0	
Next $100 of Medicare-Approved Amounts *	$0 $0	$100 (Part B Deductible)	
Remainder of Medicare-Approved Amounts	80% 20%	$0	
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $100 of Medicare-Approved Amounts *	$0 $0	$100 (Part B Deductible)	
Remainder of Medicare-Approved Amounts	80% 20%	$0	

APPENDIX B (CONT'D)
PLAN C
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

APPENDIX B (CONT'D)
PLAN C
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare-Approved Amounts * (the Part B Deductible)	$0 $100	$0	
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0 $0	All costs	
BLOOD			
First 3 pints	$0 All costs	$0	
Next $100 of Medicare-Approved Amounts *	$0 $100 (Part B Deductible)		
Remainder of Medicare-Approved Amounts	80% 20%	$0	
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $100 of Medicare-Approved Amounts *	$0 $100 (Part B Deductible)		$0
Remainder of Medicare-Approved Amounts	80% 20%	$0	
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over $50,000 life-time maximum

APPENDIX B (CONT'D)
PLAN D
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

APPENDIX B (CONT'D)
PLAN D
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare-Approved Amounts * (the Part B Deductible)	$0 $0	$100	
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0 $0	All costs	
BLOOD			
First 3 pints	$0 All costs	$0	
Next $100 of Medicare-Approved Amounts *	$0 $0	$100 (Part B Deductible)	
Remainder of Medicare-Approved Amounts	80% 20%	$0	
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $100 of Medicare-Approved Amounts *	$0 $0	$100 (Part B Deductible)	
Remainder of Medicare-Approved Amounts	80% 20%	$0	

APPENDIX B (CONT'D)
PLAN D
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
- Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit)	$0	Up to the number of Medicare-Approved visits, not to exceed 7 each week	
- Calendar year maximum	$0	$1,600	
OTHER BENEFITS			
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over $50,000 lifetime maximum

APPENDIX B (CONT'D)
PLAN E
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to recieve these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

APPENDIX B (CONT'D)
PLAN E
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare-Approved Amounts * (the Part B Deductible)	$0	$0	$100
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare-Approved Amounts *	$0		$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%		$0 $0
PARTS A & B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%		$0 $0
- Durable medical equipment			
First $100 of Medicare-Approved Amounts *	$0	$0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

APPENDIX B (CONT'D)
PLAN E
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
OTHER BENEFITS			
PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE			
Annual physical and preventive tests and services, such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over $50,000 life-time maximum

APPENDIX B (CONT'D)
PLAN F
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

APPENDIX B (CONT'D)
PLAN F
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare-Approved Amounts * (the Part B Deductible)	$0 $100	$0	
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0 100%	$0	
BLOOD			
First 3 pints	$0 All costs	$0	
Next $100 of Medicare-Approved Amounts *	$0 $100 (Part B Deductible)		
Remainder of Medicare-Approved Amounts	80% 20%	$0	
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $100 of Medicare-Approved Amount *	$0 $100 (Part B Deductible)		$0
Remainder of Medicare-Approved Amounts	80% 20%	$0	

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
OTHER BENEFITS			
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over $50,000 lifetime maximum

APPENDIX B (CONT'D)
PLAN G
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

APPENDIX B (CONT'D)
PLAN G
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare-Approved Amounts * (the Part B Deductible)	$0 $0	$100	
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0 80%	20%	
BLOOD			
First 3 pints	$0 All costs	$0	
Next $100 of Medicare-Approved Amounts *	$0 $0	$100 (Part B Deductible)	
Remainder of Medicare-Approved Amounts	80% 20%	$0	
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $100 of Medicare-Approved Amounts *	$0 $0	$100 (Part B Deductible)	
Remainder of Medicare-Approved Amounts	80% 20%	$0	

APPENDIX B (CONT'D)
PLAN G
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
- Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit)	$0	Up to the number of Medicare-Approved visits, not to exceed 7 each week	
- Calendar year maximum	$0	$1,600	
OTHER BENEFITS			
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over $50,000 life-time maximum

APPENDIX B (CONT'D)
PLAN H
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

APPENDIX B (CONT'D)
PLAN H
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare-Approved Amounts * (the Part B Deductible)	$0 $0	$100	
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0 $0	All costs	
BLOOD			
First 3 pints	$0 All costs	$0	
Next $100 of Medicare-Approved Amounts *	$0 $0	$100 (Part B Deductible)	
Remainder of Medicare-Approved Amounts	80% 20%	$0	
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $100 of Medicare-Approved Amounts *	$0 $0	$100 (Part B Deductible)	
Remainder of Medicare-Approved Amounts	80% 20%	$0	

APPENDIX B (CONT'D)
PLAN H
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
OTHER BENEFITS			
BASIC OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50% - $1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All costs
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over $50,000 lifetime maximum

APPENDIX B (CONT'D)
PLAN I
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

APPENDIX B (CONT'D)
PLAN I
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare-Approved Amounts * (the Part B Deductible)	$0	$100	
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0 100%	$0	
BLOOD			
First 3 pints	$0 All costs	$0	
Next $100 of Medicare-Approved Amounts *	$0 $0	$100 (Part B Deductible)	
Remainder of Medicare-Approved Amounts	80% 20%	$0	
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0 $0	
PARTS A & B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0 $0	
- Durable medical equipment			
First $100 of Medicare-Approved Amounts *	$0 $0	$100 (Part B Deductible)	
Remainder of Medicare-Approved Amounts	80% 20%	$0	

APPENDIX B (CONT'D)
PLAN I
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
- Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit)	$0	Up to the number Medicare-Approved visits, not to exceed 7 each week	
- Calendar year maximum	$0	$1,600	
OTHER BENEFITS			
BASIC OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50% - $1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All costs
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over $50,000 lifetime maximum

APPENDIX B (CONT'D)
PLAN J
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out patient drugs and inpatient respite care	$0	Balance

APPENDIX B (CONT'D)
PLAN J
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare-Approved Amounts * (the Part B Deductible)	$0 $100	$0	
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0 100%	$0	
BLOOD			
First 3 pints	$0 All costs	$0	
Next $100 of Medicare-Approved Amounts *	$0 $100 (Part B Deductible)	$0	
Remainder of Medicare-Approved Amounts	80% 20%	$0	
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $100 of Medicare-Approved Amounts *	$0 $100 (Part B Deductible)	$0	
Remainder of Medicare-Approved Amounts	80% 20%	$0	

APPENDIX B (CONT'D)
PLAN J
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

SERVICES	MEDICARE PAYS		PLAN PAYS	YOU PAY
AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE				
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan				
- Benefit for each visit	$0	Actual Charges to $40 a visit	Balance	
- Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit)	$0	Up to the number of Medicare-Approved visits, not to exceed 7 each week		
- Calendar year maximum	$0	$1,600		
OTHER BENEFITS				
EXTENDED OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE				
First $250 each calendar year	$0	$0 $250		
Next $6,000 each calendar year	$0	50% - $3,000 calendar year maximum benefit	50%	
Over $6,000 each calendar year	$0	$0 All costs		
PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE				
Annual physical and preventive tests and services, such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education administered or ordered by your doctor when not covered by Medicare				
First $120 each calendar year	$0	$120		$0
Additional charges	$0	$0 All costs		

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
OTHER BENEFITS (continued)			
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over $50,000 lifetime maximum

APPENDIX C

[Statements]

1. You do not need more than one Medicare supplement policy.

2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

~~2~~3. ~~If you are 65 or older, you~~ You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

~~3~~4. The benefits and premiums under your Medicare supplement policy ~~will~~ can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstated if requested within 90 days of losing Medicaid eligibility.

~~4~~5. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

[Questions]

To the best of your knowledge,

1. Do you have another Medicare supplement policy or certificate in force~~, including health care service contract, health maintenance organization contract~~?
   a. If so, with which company?
   b. If so, do you intend to replace your current Medicare supplement policy with this policy [certificate]?

2. Do you have any other health insurance ~~policies~~ coverage that provides benefits ~~which~~ similar to this Medicare supplement policy [certificate] ~~would duplicate~~?
   a. If so, with which company?
   b. What kind of policy?

~~3. If the answer to question 1 or 2 is yes, do you intend to replace these medical or health policies with this policy [certificate]?~~

~~4~~3. Are you covered ~~by~~ for medical assistance through the state Medicaid program:~~?~~
   a. As a Specified Low Income Medicare Beneficiary (SLMB)?
   b. As a Qualified Medicare Beneficiary (QMB)?
   c. For full Medicaid Benefits?

APPENDIX D
NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by [company name) Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully, compare it with all accident and sickness coverage you now have. ~~Terminate your present policy if~~ If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement policy. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. ~~The replacement of insurance involved in this transaction does not duplicate coverage, t~~To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement coverage because you intend to terminate your existing Medicare supplement coverage. The replacement policy is being purchased for the following reason(s) (check one):

____ Additional benefits
____ No change in benefits, but lower premiums
____ Fewer benefits and lower premiums
____ Other (please specify) _____

_____

_____

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____
(Signature of Agent, Broker or Other Representative)*
[Typed Name and Address of Issuer, Agent or Broker]

_____
(Applicant's Signature)

_____
(Date)

*Signature not required for direct response sales.

Appendix F

MEDICARE DUPLICATION DISCLOSURE STATEMENTS

Instructions for use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries that Duplicate Medicare

1. Federal law, P.L. 103-432, prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.

2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).

3. State and Federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.

4. Property/Casualty and Life insurance policies are not considered health insurance.

5. Disability income policies are not considered to provide benefits that duplicate Medicare.

6. The federal law does not pre-empt state laws that are more stringent than the federal requirements.

7. The federal law does not pre-empt existing state form filing requirements.

[For policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For policies that reimburse expenses incurred for specifiied disease(s) or other specified impairment(s). This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For policies that pay fixed dollar amounts for specified disease(s) or other specified impairment(s). This includes cancer, specified disease and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For long-term care policies providing both nursing home and non-institutional coverage.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates Medicare benefits in some situations.

- This is long-term care insurance that provides benefits for covered nursing home and home care services.
- In some situations Medicare pays for short periods of skilled nursing home care, limited home health services and hospice care.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most long-term care expenses.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about long-term care insurance, review the *Shopper's Guide to Long-Term Care Insurance, available from the insurance company.*
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For long-term care policies providing nursing home benefits only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates Medicare benefits in some situations.

- This insurance provides benefits for covered nursing home services.
- In some situations Medicare pays for short periods of skilled nursing home care and hospice care.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most nursing home expenses.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about long-term care insurance, review the *Shopper's Guide to Long-Term Care Insurance, available from the insurance company.*
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For policies providing home care benefits only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates Medicare benefits in some situations.

- This insurance provides benefits primarily for covered home care services.
- In some situations, Medicare will cover some health related services in your home and hospice care which may also be covered by this insurance.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most services in your home.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about long-term care insurance, review the *Shopper's Guide to Long-Term Care Insurance, available from the insurance company.*
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.